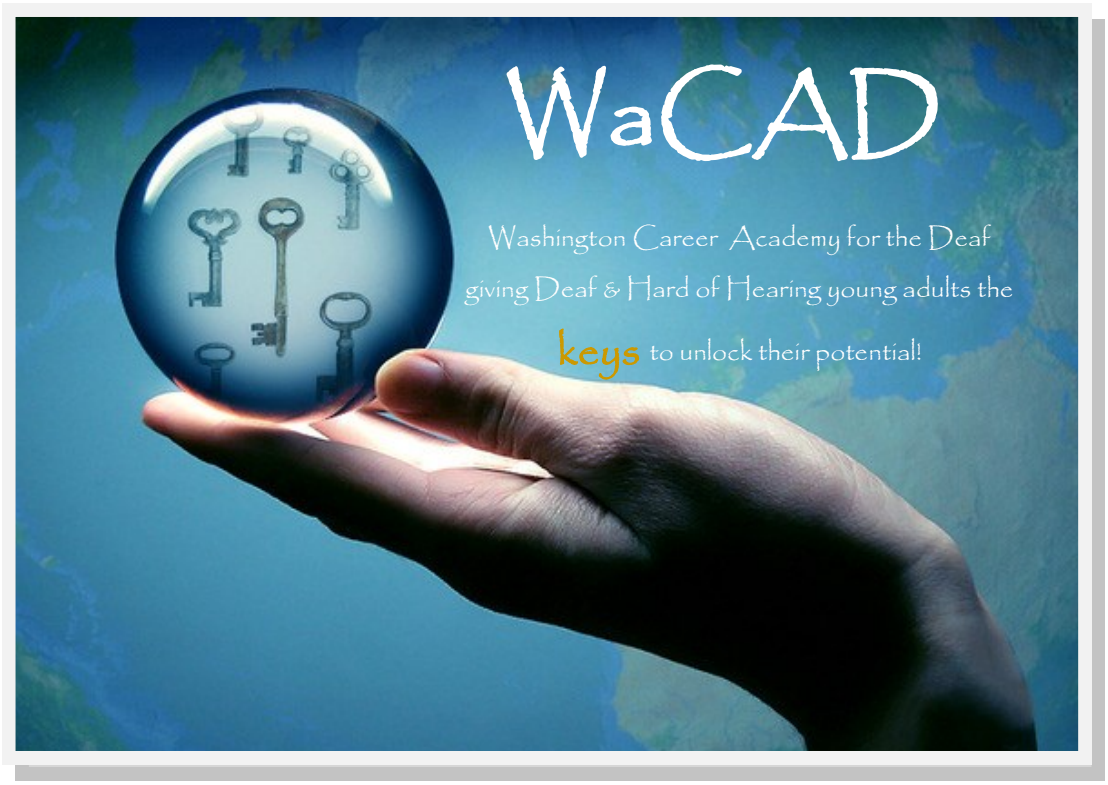
# Washington Career Academy for the Deaf

# Application Packet




## Washington Career Academy for the Deaf (WaCAD)

Washington School for the Deaf (WSD)
Center for Childhood Deafness & Hearing Loss (CDHL)
611 Grand Blvd, Vancouver, WA 98661
(360) 696-6525 (V/TTY) / (800) 613-4228 / www.wsd.wa.gov
Division of Vocational Rehabilitation (DVR)
State of Washington

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# PARTICIPANT INFORMATION

## STUDENT INFORMATION

PLEASE CIRCLE ONE THAT APPLIES:

*Are you:* ASL User  Hard of Hearing  Oral with sign  Oral without sign

| | | | |
|---|---|---|---|
| STUDENT'S NAME LAST | | FIRST | MIDDLE |
| ADDRESS STREET | | CITY | STATE/ZIP |
| HOME TELEPHONE NUMBER | WORK TELEPHONE NUMBER | EMAIL/PAGER ADDRESS | |
| BIRTHDATE | AGE | GENDER | COUNTY OF RESIDENCE |
| EMERGENCY CONTACT | NAME | RELATIONSHIP | PHONE NUMBER |

## BACKGROUND INFORMATION

PLEASE PLACE AN 'X' NEXT TO THE AREAS YOU NEED HELP WITH

| | | | |
|---|---|---|---|
| | Balancing a checkbook/Budgeting Money | | Using public transportation |
| | Paying bills (rent, heat, water, garbage) | | Buying a car |
| | Looking for a job | | Taxes |
| | Applying for a job | | Organizational skills |
| | Grocery shopping | | Social Skills |
| | Cooking/preparing meals | | Self Advocacy |

| | | |
|---|---|---|
| Are you a U.S. Citizen? | Yes | No |
| If no, do you have a work permit? | Yes | No |
| Permanent Resident Card | Yes | No |
| Green Card/Student Visa | Yes | No |
| Are you certified in CPR/First Aid? | Yes | No |
| Do you have a food handler's card? | Yes | No |
| Do you have a DVR Counselor? | Yes | No |

If yes, name of DVR Counselor and telephone number:_____

Check Program (s) you may be interested in: _____Community College _____Vocational/Technical _____Work Experience

# EDUCATION/Release of Information

Name_____

High School Attended_____Fax Number_____

High School Attended_____Fax Number_____

*High School Transcript or GED Certificate*
*IEP Transition/Summary of Performance*

## PLEASE SEND REQUESTED INFORMATION TO:

Dan Crady–WaCAD Coordinator
Washington School for the Deaf
611 Grand Boulevard
Vancouver, WA 98661
Fax: (360) 696–6291 Office: (360) 696–6525

## Release of Information:

I, _____authorize the above listed school(s) agencies to release records listed above.
All information shared will be treated in a confidential manner.

Signature_____ Date_____

PLEASE ANSWER THE FOLLOWING QUESTIONS

Name_____

1. Why do you want to join the Washington Career Academy for the Deaf?

2. What are two goals you have for your future?

(A)

(B)

# EMPLOYMENT HISTORY

Name_____

## EMPLOYMENT HISTORY

| 1. PRESENT OR LAST EMPLOYER | | EMPLOYER'S ADDRESS |
|---|---|---|
| EMPLOYER'S PHONE NUMBER | YOUR TITLE | MONTHS & YEARS EMPLOYED IN THIS POSITION<br>FROM _____/_____ TO _____/_____ |
| TOTAL MONTHS EMPLOYED | AVERAGE HOURS/WEEK | IMMEDIATE SUPERVISOR'S NAME |
| REASON FOR LEAVING | | VOLUNTEER POSITION (YES/NO) |

SPECIFIC DUTIES:

_____

_____

_____

_____

| 2. PREVIOUS EMPLOYER | | EMPLOYER'S ADDRESS |
|---|---|---|
| EMPLOYER'S PHONE NUMBER | YOUR TITLE | MONTHS & YEARS EMPLOYED IN THIS POSITION<br>FROM _____/_____ TO _____/_____ |
| TOTAL MONTHS EMPLOYED | AVERAGE HOURS/WEEK | IMMEDIATE SUPERVISOR'S NAME |
| REASON FOR LEAVING | | VOLUNTEER POSITION (YES/NO) |

SPECIFIC DUTIES:

_____

_____

_____

List any certificates received_____

List any other non-paid work experience or volunteer positions:

_____

_____

PLEASE LIST THE TYPES OF JOBS YOU ARE INTERESTED IN:

1._____

2._____

3._____

# REFERENCES

List three references that are not relatives or close friends. Teachers, employers, supervisors and/or group leaders are preferred. Be sure to inform your references they may be receiving a call.

Name_____

REFERENCES

| REFERENCE ONE | | | |
|---|---|---|---|
| NAME LAST | FIRST | RELATIONSHIP | |
| ADDRESS STREET | CITY | STATE/ZIP | |
| HOME PHONE NUMBER | WORK PHONE NUMBER | CELLULAR PHONE NUMBER | |
| EMAIL/PAGER ADDRESS | | | |

| REFERENCE TWO | | | |
|---|---|---|---|
| NAME LAST | FIRST | RELATIONSHIP | |
| ADDRESS STREET | CITY | STATE/ZIP | |
| HOME PHONE NUMBER | WORK PHONE NUMBER | CELLULAR PHONE NUMBER | |
| EMAIL/PAGER ADDRESS | | | |

| REFERENCE THREE | | | |
|---|---|---|---|
| NAME LAST | FIRST | RELATIONSHIP | |
| ADDRESS STREET | CITY | STATE/ZIP | |
| HOME PHONE NUMBER | WORK PHONE NUMBER | CELLULAR PHONE NUMBER | |
| EMAIL/PAGER ADDRESS | | | |

# VEHICLE REGISTRATION FORM

| (PRIMARY VEHICLE) | | | |
|---|---|---|---|
| *NAME AS IT APPEARS ON YOUR LICENSE*<br>LAST FIRST MIDDLE | | | |
| MAKE | MODEL | COLOR | YEAR |
| LICENSE PLATE # | INSURANCE COMPANY | AGENT NAME/PHONE NUMBER | |
| **(ALTERNATE VEHICLE #1)** | | | |
| MAKE | MODEL | COLOR | YEAR |
| LICENSE PLATE # | INSURANCE COMPANY | AGENT NAME/PHONE NUMBER | |
| **(ALTERNATE VEHICLE #2)** | | | |
| MAKE | MODEL | COLOR | YEAR |
| LICENSE PLATE # | INSURANCE COMPANY | AGENT NAME/PHONE NUMBER | |

## Attach a copy of the following for our records

Automobile Insurance Card

Driver's License

*(OFFICE USE ONLY)*

Primary Vehicle Identification Tag # _____

Alternate Vehicle #1 Identification Tag # _____

Alternate Vehicle #2 Identification Tag # _____

# DISCLOSURE STATEMENT

*This disclosure statement shall be completed and signed prior to acceptance into the WaCAD program at the Washington School for the Deaf.*

1. Have you ever been charged/adjudicated for violent offenses? _____ YES _____ NO

   If yes, what for? _____ when?_____

   By which police department_____

2. Have you been charged/arrested/adjudicated for any sexual offenses? _____ YES _____ NO

   If yes, what for? _____ when?_____

3. Are you a registered sex offender? _____ YES _____ NO

   If yes, what state? _____ what county?_____

4. Have you ever been suspended from school? _____ YES _____ NO

   If yes, why?_____ when? _____

   Where? (school name)_____

5. Have you ever been expelled from school? _____ YES _____ NO

   If yes, why? _____ when? _____

   Where? (school name) _____

6. Have you in the past or are you currently receiving Mental Health services? _____ YES _____ NO

   If yes, what for? _____

   Name of agency/clinic _____

7. Have you ever tried to harm yourself? _____ YES _____ NO

   If yes, when? _____ What was the outcome? _____

8. Do you have a history of drugs or alcohol abuse? _____ YES _____ NO

   If yes, what kind? _____ How often? _____

9. Have you ever been involved with Child Protective Services (CPS)? _____ YES _____ NO

   If yes, explain _____

10. Do you have any ongoing needs related to severe emotional, behavioral or mental disorder? _____ YES _____ NO

    If yes, explain _____

11. Do you have a psychiatric diagnosis by a psychiatrist or a provisional/suspected diagnosis by a mental health therapist? _____ YES _____ NO

    If yes, explain_____

12. Do you need any special accommodations? _____ YES _____ NO

    If yes, explain _____

I authorize the Washington School for the Deaf to conduct a background check on me. I certify under penalty of perjury, under the laws of the State of Washington that the above information is true and correct.

_____/_____ _____

Date of Birth Social Security Number Maiden Name of other aliases used

_____ _____

Print Full Name Signature

_____ _____

Date Place signed (city/state)